Designing a Comprehensive, Coordinated Managed System of Care for Publicly Funded Alcohol and Other Drug Services in California

Briefing Paper and Preliminary Recommendations Report

Prepared for Review and Discussion by the
Managed Care Policy Advisory Committee (MCPAC)
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PREFACE AND ACKNOWLEDGMENTS

This report is presented for review by the alcohol and other drug services field, ancillary service systems, consumers and the general community. It has been developed over the past year as a statewide collaborative effort under the auspices of the Managed Care Policy Advisory Committee (MCPAC). Many of the MCPAC participants have served on specialty topic Work Teams to develop and present the information and preliminary recommendations contained herein.

As identified by MCPAC participants, the narrative discussions and preliminary recommendations presented define the key elements for providing alcohol and other drug services in a managed care environment and outline the critical issues that need to be addressed in designing a statewide system of alcohol and other drug services utilizing managed care constructs. They reflect a compilation of the related issues analyzed and discussed by MCPAC participants and do not necessarily reflect a consensus of opinion in each of the system design elements. Thus, the preliminary recommendations presented herein require continued in-depth development and analysis by the alcohol and drug field prior to presenting formal or final recommendations for establishing an Alcohol and Other Drug Managed System of Care in California. The full range of potential consequences of implementing any or all of the recommendations will be explored in depth in the months ahead.

Special acknowledgment is given to the following alcohol and other drug service, advocacy and policy associations that have been actively committed to supporting this complex, collaborative effort with their invaluable leadership, expertise, time and resources:

County Alcohol and Drug Program Administrators Association of California (CADPAAC)
California Association of Addiction Recovery Resources (CAARR)
California Association of Alcohol and Drug Program Executives (CAADPE)
California Organization of Methadone Providers (COMP)
DADP's Director's Advisory Council (DAC) / Constituency Committees
Center for Substance Abuse Treatment / Prevention (CSAT and CSAP)
State Department of Alcohol and Drug Programs (DADP)

It is important to note that the issues and recommendations presented do not reflect a consensus of opinion in areas discussed, but rather a compilation of key issues discussed by the participants.

The Committee wishes to acknowledge the Department of Alcohol and Drug Programs' support in the process to explore managed care and the development of this briefing paper through its funding of technical resources necessary to the work of the Committee. However, the Committee also notes that the recommendations may not reflect positions of the Administration at this time.

In designing a comprehensive, coordinated system of care to deliver alcohol and other drug services in California, an "Alcohol and Other Drug Managed System of Care" is defined as:

"A planned approach to delivering quality, comprehensive alcohol and other drug prevention, intervention, treatment and recovery services to individuals and groups through a coordinated system of care in which prospective payment is made to managed care organizations that serve defined populations who are eligible to receive specific services."

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I. Introduction

A. Why a Coordinated System of Care for Publicly Funded Alcohol and Other Drug Services in California?

Health care reform, through the vehicle of managed care concepts, continues to dominate the health services environment in which the publicly funded alcohol and other drug service system operates. Health care costs continue to escalate at a rate that exceeds normal rates of inflation: hospital bed capacity is being utilized at approximately 50%, thereby further driving up costs, and technology, while providing greater capability of sustaining life, further contributes to escalating costs. Yet approximately 20% of the nation's population is not covered by private insurance, Medicare or Medicaid. Uncovered individuals often do not seek medical services until their disease or condition progresses to a stage that is critical or life threatening, frequently requiring care to be delivered in emergency settings which are the most costly service environments in health care systems.

In the alcohol and other drug services field, this delay in access to appropriate care is frequently the experience of the public sector alcohol and other drug client/ participant. They are often confronted with the traditional barriers of limited financial resources, restrictive eligibility criteria, and limited geographic access. In addition, individuals confront alcohol and other drug-specific barriers to receiving services such as personal and societal denial, fear of reprisal, criminal justice intervention, financial crises, or loss of children, family or employment if their alcohol and other drug problem(s) become known. Also, service delivery which meets the cultural, ethnic, linguistic, social or lifestyle needs of the multiple diverse populations in California has been limited.

As a result of these issues, there are large waiting lists for youth and adults to receive alcohol and other drug treatment/recovery services. According to statistics provided by the California Department of Alcohol and Drug Programs, there are currently approximately 7,500 individuals on waiting lists throughout California. Additionally, the youth and adolescent populations at risk of foster placement, as well as the criminal justice system population, are emerging as needing more alcohol and other drug services than are currently available. It is well known that alcohol and other drug treatment and recovery programs are both successful and cost effective, with every dollar spent on alcohol and other drug services resulting in $7 - $12 of savings in criminal justice, primary health care costs, and employee productivity (CALDATA study). Yet in spite of the data, the public's understanding of alcohol and other drug problems remains limited, as do financial resources to address the problems.

In addition, it is desirable for other service systems that serve significant numbers of clients with alcohol and other drug related problems to make more investments in the expansion of alcohol and other drug treatment/recovery programs for their specific target populations. Although the California Department of Corrections has

taken the initiative in utilizing its resources to develop treatment and recovery programs for the parolee population, such efforts will need to be greatly enhanced and implemented by other service systems to insure that the alcohol and other drug field will be able to effectively serve individuals and communities with multiple needs. Success in this area of public health care will rely upon developing collaborative partnerships and resource sharing among the alcohol and other drug field and allied service systems.

As a response to the many issues described above, the ***principles of managed health care*** present the alcohol and other drug field with both opportunities and challenges to delivering quality, comprehensive alcohol and other drug prevention, intervention, treatment and recovery services to the diverse constituencies throughout California. If successfully implemented, managed care has the capacity of offering the alcohol and other drug field a disciplined and consistent approach to service delivery that will lead to clients/participants receiving timely access to quality, comprehensive, coordinated care resulting in improved outcomes, service system accountability, client/participant satisfaction, and cost effectiveness.

As alcohol and other drug services move toward managed care constructs, it will be necessary to clearly articulate the alcohol and other drug field's definition of *managed care* to insure consistent understanding of the purpose of implementing these concepts in the alcohol and other drug service system. Historically, many people have perceived managed care negatively, implying restricted client/participant access to services and delivering the lowest level of care for the least cost. While providing cost efficient care is certainly one goal of a managed care system, it is not the only one. Thus, any effort that moves the alcohol and other drug field toward improved prevention, intervention, treatment and recovery services and increased accountability needs to remain committed to basic, primary principles. Maximum flexibility in local planning and control must be strongly supported to ensure effective responses to individual community characteristics and needs.

In an effort to utilize managed care principles in the most effective manner, an *Alcohol and Other Drug Managed System of Care is defined as a planned approach to delivering quality, comprehensive prevention, intervention, treatment and recovery services through a coordinated system of care in which clients/participants are provided with the most appropriate level of service in order to achieve the best possible client/participant outcomes while utilizing funding resources efficiently.*

B. Process for Designing a Comprehensive, Coordinated Managed System of Care for Publicly Funded Alcohol and Other Drug Services in California: Role of the Managed Care Policy Advisory Committee (MCPAC)

In an effort to deliver excellent alcohol and other drug services in an era of rapidly changing social and economic policies, many alcohol and other drug service agencies and associations throughout the State have been engaging in strategy sessions to proactively plan for the impact of health care reform and the rapid development of managed care systems in the public sector. Outcomes of the work of these groups resulted in creation of the Managed Care Policy Advisory Committee (MCPAC), a cooperative venture of the State Department of Alcohol and Drug Programs, the County Alcohol and Drug Program Administrators Association of California (CADPAAC), the California Association of Alcoholic Recovery Homes (CAARH), the California Association of Alcohol and Drug Program Executives (CAADPE), the California Organization of Methadone Providers (COMP), the Director's Advisory Council (DAC) and Constituency Committees, and many other statewide alcohol and other drug provider, policy and constituency groups.

The primary goal of the Managed Care Policy Advisory Committee is to study and recommend a programmatic, fiscal and administrative managed system of care design for the delivery of alcohol and other drug services that:

- provides timely access to specialized alcohol and other drug services;
- ensures the continued delivery of quality, comprehensive care;
- creates formal linkages with primary health care and ancillary service systems;
- develops measurements to improve and evaluate client/participant and provider outcomes;
- implements practice standards to support continuous quality improvement and service efficiency; and,
- develops methods to assess client/participant satisfaction for California's diverse and growing population in need of alcohol and drug services.

A comprehensive managed system of care will be inclusive of alcohol and other drug prevention, intervention, treatment, and recovery services. Provision of services must encompass social, community and medical care models, and the system must maintain an active commitment to cultural/ ethnic/ lifestyle/ linguistic competency, disability access, client confidentiality, client "choice" of service, and participation in treatment/recovery planning for **all** populations in California. It is critical that **all** stakeholders be involved throughout the system design process and that serving the needs of clients always retain first priority.

Currently, the MCPAC structure includes over 70 participants statewide (see appendix for "MCPAC Participant/Mailing List"). Subcommittees, or "work teams," meet as needed to provide additional research and to develop recommendations. The MCPAC also coordinates its efforts with existing statewide and national work groups and entities that are engaged in addressing issues that

impact the development and successful implementation of an alcohol and other drug managed system of care in California. (See "Process Map" in appendix.)

II. Describing Managed Care for Alcohol and Other Drug Services: System Definition, Goals and Guiding Principles

Managed Care is a planned, comprehensive approach to the provision of health care which provides a model for the delivery of services and the application of consistent administrative procedures within an integrated, coordinated system. Individual providers are linked together into a system that formalizes provider relationships and brings them together under the umbrella of a single entity, the Managed Care Plan. The arrangement is formal and contractual. Provider agreements cover not only provider fees, but indicate how practice management will be conducted, what steps will be taken to measure and evaluate quality, and how client satisfaction will be determined. This specialty service system formally establishes collaborative relationships and comprehensive service agreements with other public and private human and community service systems to insure that ancillary and inter-connected services are provided to clients/participants.

The goal is to deliver the highest quality, culturally competent, cost effective array of alcohol and other drug prevention, treatment and recovery services to individuals, families and communities affected by substance abuse and related problems. Another goal is to provide leadership in developing and actively participating in cooperative and collaborative partnerships with other public and private sector service systems and communities in order to reduce the level of alcohol and other drug related problems in the State of California.

Specific objectives include:

1. To enhance and ensure access to alcohol and other drug prevention, intervention, treatment and recovery services by all eligible populations;
2. To enhance the quality and effectiveness of alcohol and other drug services;
3. To enhance coordination, linkages and access with ancillary service systems;
4. To ensure alcohol and other drug service system accountability and continued quality improvement; and,
5. To improve client/participant outcome measurements.

An Alcohol and Other Drug Managed System of Care would be committed to the following principles:

1. Promote, advocate and support alcohol and other drug services as a unique, distinct and organized service specialty that reduces the level of alcohol and other drug related problems of individuals, communities and society.
2. Promote, advocate and support alcohol and other drug services/programs that provide high quality and culturally competent prevention, treatment and recovery

services that result in positive client/family/community outcomes and client/participant satisfaction.

3. Promote access to a full array of alcohol and other drug services/programs to the highest number of clients/participants in the most cost efficient manner possible while employing creative funding strategies for maximum revenue generation.
4. Promote improved treatment and recovery outcomes through better communication, coordination, cooperation and collaboration with other service systems.

III. Description of the Current Alcohol and Other Drug Service System in California and Areas for Improvement

A. Unique and Distinct Service Specialty

Alcohol and drug services have unique characteristics which distinguish them from other service systems. Some of these unique characteristics include:

1. **Environmental Influences:** Alcohol and drug problems are greatly influenced by environmental factors. Therefore, alcohol and other drug services should continue to focus on prevention and early intervention with a special emphasis on environmental factors, e.g., community norms, public policy on availability, and education. Treatment interventions earlier in the disease process are often highly effective for persons with alcohol and other drug problems. In addition, maintaining a culture of sobriety in treatment/recovery programs is a critical environmental influence promoting recovery.

2. **Target Populations:**
   - The alcohol and other drug field has a very broad target population (generally, at or below poverty) with a relatively high incidence of alcohol and other drug problems when compared with the general population. The field is therefore able to reach only a portion of the persons in need.

   - Alcohol and other drug services frequently concentrate on persons with higher levels of functioning, but providers must manage their funds to decrease the costs of alcohol and other drug use/abuse in the entire society (individual problems, economic consequences, criminal justice system, health, welfare, child protective services, etc.). Therefore, providers tend to provide the greatest number of people with prevention, treatment or recovery services rather than focusing on the most severely impaired clients. This has tended to diminish the use of the highest cost services within the AOD system of care, keeping the overall costs of the system very efficient.

3. **Medical Support:** Medical services for alcohol and other drug problems tend to be focused on acute, short-term stabilization (for example, detoxification)

rather than long-term maintenance. Alcohol and other drug services can usually be provided at a lower cost per client due to the widespread use of skilled and trained paraprofessional recovering staff rather than credentialed/licensed staff. This type of support is not required by the majority of the AOD population.

It is vital that the alcohol and other drug field support alcohol and other drug services as a unique and distinct system of care. A defined alcohol and other drug system which prioritizes the delivery of specialized services by experienced and trained practitioners must be maintained and strengthened if California is to maintain its commitment to preventing and reducing the serious health, social, criminal justice, and economic problems created as a result of the misuse of alcohol and other drugs.

B. Alcohol and Other Drug Prevention, Intervention, Treatment and Recovery Services in California

Prevention, intervention, treatment and recovery services include a wide variety of individual, group and community approaches. Community outreach and education, including involvement by schools, civic and service clubs and the media are frequent prevention strategies. Intervention, treatment and recovery services frequently involve educational activities, individual and group counseling sessions, recovery and treatment planning, alcohol and other drug detoxification and chemically assisted maintenance programs in the community and in residential and non-residential treatment and recovery settings.

Detoxification programs support and assist individuals during a period of planned withdrawal from alcohol and drug dependency and provide support systems to assure continued recovery. Nonresidential treatment and recovery programs provide individual and group alcohol education and recovery services, utilizing a supportive approach for individuals not requiring a residential setting. These services include: self-help groups, community recovery centers, outpatient clinics, day treatment and recovery program, and drinking driver programs.

Prevention and early intervention activities including community education and environmental strategies that advocate for change in social policies, norms, and practices regarding misuse and abuse of alcohol and other drugs are grounded in a public health model and contain important elements of both social and medical model treatment philosophies.

Most programs provide services that represent variations on the clinical treatment model or the social model. Although the two models are distinctly different, they have many similarities. As determined by individual client/participant needs, alcohol and other drug programs often incorporate aspects of each model in their treatment and recovery services plans.

The social model recovery philosophy and approach was initially developed in alcohol recovery programs. Over the years it has been adapted for use in many drug treatment programs. Initially, a social model program was defined in contrast to a medical model program: as community-based and home-like without hospital setting, physician direction, or emphasis upon medication. Key elements in Social Model services include: utilizing the experience of recovering alcoholics/addicts, utilizing the 12-step recovery process, accepting recovery as a life-long process, lack of therapist-client roles, participants voluntarily sharing in responsibilities of the programs they are involved in, and clients enjoying a relationship with staff and volunteers similar to an extended family network. The recovery process and programs are shared with the clients, family and community levels.

The clinical treatment and recovery model is generally defined in terms of professional medical practice in alcohol and other drug treatment. It is similar to social model in its focus to improve an individual's overall health and level of functioning by offering education, individual and group counseling and 12-step or peer support recovery. It differs by de-emphasizing peer support and focuses on clients requiring medical services such as medication-assisted detoxification, methadone maintenance, and therapeutic counseling. Clinical model services are generally delivered in outpatient or residential clinics and hospitals which utilize personnel who are formal trained and have professional degrees.

C. Role of the State Department of Alcohol and Drug Programs (DADP)

The State Department of Alcohol and Drug Programs' goal is to ensure the availability, effectiveness and efficiency of statewide alcohol and other drug services that are administered or provided by county governments to Californians who require prevention/treatment/recovery services. The department is organized into the following five major areas: (1) Program Operations, (2) Quality Assurance, (3) Children, Youth, Family and Community Services, (4) Information Management Services, and (5) Administration. The department also implements extensive prevention strategies and contracts out special projects and programs designed to reduce the incidence of alcohol- and drug-related problems in the general population, with special emphasis directed toward ethnic minorities, women, youth, elderly, and the disabled. Through coordination of these efforts, DADP intends to reduce the socio-economic costs to Californians, estimated at $17 billion annually, as a result of alcohol and other drug related problems.

The State Department of Health Services (DHS) continues to be the Single State Agency (SSA) for the administration of Medi-Cal benefits. The State Department of Alcohol and Drug Programs (DADP) has been delegated authority to administer the specific Drug/Medi-Cal benefits. This authority and administrative parameters are outlined in an annual Interagency Agreement between the two Departments.

Relative to federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding, the DADP is the SSA responsible for the administration of all services and funding requirements.

Generally, the State has the following responsibilities and authorities:

1. Administration and financing (non-federal share) of the Medicaid Fee-for-Service benefits (DHS).

2. Administration of the optional Drug/Medi-Cal benefit package (DADP).

3. Overall statewide financial authority, which includes the development of state-wide allocation formulas for both federal SAPTBG and State General funds; maintaining liaison with federal agencies; and financial auditing processes (DADP).

4. Development, negotiation, and administration of the Negotiated Net Amount (NNA) contracts and Drug/Medi-Cal contracts, which are the current funding mechanisms (DADP).

5. Quality assurance, which includes facility licensing, program certification, Drug/Medi-Cal certification, program standards, program monitoring and utilization review requirements (DADP).

6. Development of a statewide MIS and data collection/reporting system, which includes specialized research, evaluation and survey projects (DADP).

7. Policy and regulatory development, including inter-governmental and inter-agency collaboration, to facilitate the implementation of alcohol and other drug services (DADP).

DADP administers the State system of alcohol and other drug services in partnership with 57 county alcohol and drug agencies (Sutter and Yuba Counties have combined administrations). Each county contracts with the State for State General Fund and federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding. The nineteen smallest counties in population receive a minimum base allocation that is intended to fund a base level of services in those counties. The other counties receive allocations based partly on historical grant award levels, partly on current population per capita amounts, and partly on step-up formulas intended to bring lower per capita counties up to parity with a statewide per capita amount.

With these funds, the counties plan and administer a local system of services appropriate to the local needs, as approved by each county's Board of Supervisors. The counties receive funds under terms and conditions of a State-County contract, as well as pertinent federal laws and regulations for the various federal grants.

D. Areas for Improvement of the Current Alcohol and Other Drug System

While the current system has made great strides in its ability to serve the diverse and changing populations of California, there are several areas that could be improved.

Assessment and Placement: Major differences between social model recovery and medical model approaches, as well as historically separate funding for alcohol and drugs, followed by a merging of the two fields, have resulted in diverse approaches to client/participant service need assessment and placement. Thus, there is a need to create methods to assist the field in developing uniform standards for alcohol and other drug service need assessment and programmatic protocols. Protocols that provide for better program matching for client/participant needs and improved ability to manage clients both upward and downward in service intensity are desirable.

Administration Processes: With the field's history of limited funding as compared to the growing need for services, universal administrative and coordination processes, advanced computerized information systems, and other management tools have not been utilized or developed. These items have not been top funding priorities, as resources have been allocated to the provision of direct alcohol and other drug services.

Funding: The alcohol and other drug field would also benefit by considering modifications to the system that could accommodate a consolidation of program and funding sources (Drug/Medi-Cal, Federal, private insurance, and state block grants) as appropriate to support access to a full array of alcohol and other drug services.

To improve the overall quality of current alcohol and other drug services, other areas requiring improvement include the following:

1. Increased access to and coordination of the system;
2. Establishment of uniform practice standards for service providers and staff;
3. Decisions need to be made regarding who the field will not serve, as well as who it will serve;
4. Services can be more cost effective, matching clients to appropriate levels of care with consideration of individual need, strengths, and choice;
5. Institutionalized linkages need to be developed and maintained with allied service systems, such as criminal justice, public/primary health, mental health, social services, rehabilitation services, and education; and,
6. Public/private partnerships need to be advanced in a manner that enhances client access and maximizes resources.

IV. Description of the Basic Components of an Alcohol and Other Drug Managed System of Care and Preliminary Recommendations

Many individuals in the publicly funded health field perceive managed care as synonymous with Medicaid managed care. However, regardless of whether California sustains any or all of the optional Drug/Medi-Cal treatment benefit, managed care principles will exert a significant influence over the administration and management of any health service system into the foreseeable future.

At a minimum, the following elements should be included in an alcohol and other drug managed system of care design:

1. A defined array of prevention, intervention, treatment and recovery services;
2. Administrative, financial and operating systems that manage access to and utilization of alcohol and other drug services;
3. Standardized statewide intake assessment criteria/protocols;
4. Quality assurance standards and protocols;
5. Commonly held definitions for outcome measures;
6. Standards/certification for practitioners;
7. Certification/Licensing for programs; and,
8. Common, sophisticated data collection at all levels of the AOD service system.

Although current California alcohol and other drug services include elements of the components listed above, they have not been developed to the extent needed to implement a comprehensive, statewide system of care.

A. Target and Priority Populations

Given the changing priorities and public policies concerning the health and social services environments, the alcohol and other drug field will need to develop creative solutions to effectively serve the diverse and growing population with alcohol and other drug related problems.

In the current alcohol and other drug service system, the federal SAPT Block Grant funding maintains specific set-aside requirements for pregnant and parenting women and HIV early intervention services and, to a lesser extent, those clients with potential tuberculosis exposure. The SAPT Block Grant mandates that 20% of these funds are dedicated to primary prevention services, a minimum of 35% of SAPTBG funds are to be spent on alcohol programs, and a minimum of 35% are to be spent on drug abuse programs. To the extent that all of the above conditional requirements are met by the State and counties, the remaining funds are considered discretionary. The SAPTBG funding does not require that severity or functional levels be considered as priority criteria for client admission to treatment and recovery programs.

The Drug/Medi-Cal program services assume the eligible target populations for Medi-Cal, which tends to focus on individuals (primarily women and children) qualifying for Aid to Families with Dependent Children (AFDC) and disabled individuals qualifying for SSI/SSP as a result of drug addiction and alcoholism. Individuals must meet medical necessity criteria to qualify for admission and continuation in treatment.

The federal government is considering legislative changes which may effect the following areas:

1. SAPTBG categorical requirements may be significantly reduced, thereby allowing for greater local discretion for determining service priorities and target populations.

2. Drug and alcohol addition has been eliminated as a basis for SSI disability. Recent statutory requirements limit the current benefit to a maximum of 36 months. These actions will tend to shift this population from Drug/Medi-Cal services to other funded services, primarily SAPT Block Grant, placing greater demands upon those services.

3. Federal Medicaid funds may be capped and block granted to States.

4. Welfare Reform which may place further demand on the alcohol and other drug service system, due to the referral of welfare clients to AOD services as AOD issues are recognized as a significant barrier to employment.

RECOMMENDATIONS re: Target and Priority Populations in an AOD Managed System of Care

1. Depending on the methodology for allocating public sector AOD funds in the future, the AOD field will be required to select and target those populations that will be eligible to receive AOD services. Policies to determine how eligible population groups will be prioritized need to be developed and agreed upon by the AOD field.

2. Publicly funded alcohol and other drug treatment and recovery services should be prioritized for individuals, including their families and significant others, who do not have access to other benefits, have no insurance, or have no ability to pay.

3. Publicly funded alcohol and other drug treatment and recovery services should be targeted and prioritized for individuals of all ages who meet both the financial need described above and who meet alcohol and other drug service necessity criteria. Individuals who can afford to pay for services and/or have private insurance or other financial resources, and who meet AOD service necessity criteria, may also be served by public sector AOD service providers using their private funding sources.

4. Counties and communities should have the ability to designate priority populations based upon local/regional needs, demographic composition and community goals. AOD services should be responsive to the special cultural, ethnic, linguistic, lifestyle and disability characteristics of the population and address the unique needs of rural/frontier communities throughout California.

5. Allied service systems including, health, mental health, social services and criminal justice should work with the AOD field to enhance formal collaborative partnerships with the specialized AOD service system to ensure the timely provision of AOD services to their respective target populations.

B. Alcohol and Other Drug Managed System of Care Administration and Financing

Currently, public sector alcohol and other drug services are fiscally administered under a State to county contracting process. Drug/Medi-Cal is a fee-for-service structure and SAPTBG is a purchaser of dedicated service capacity. Counties have the authority to subcontract any or all of the SAPTBG alcohol and other drug services. Under Drug/Medi-Cal, counties are required to contract with any State certified Drug/Medi-Cal provider. Under this system, the State and counties act as funding intermediaries without the authority to manage client access, service placement or cost of services.

While one reason for developing an alcohol and other drug managed system of care has been the need for redesign of the Drug/Medi-Cal benefit system, it will be strategically advantageous to continue to align the Drug/Medi-Cal services with SAPTBG services under the same management, gatekeeper and brokerage system. This does not necessarily require that these separate funding sources will be capitated under the same financial system. However, maintaining the same management system over the entire array of services will facilitate the maximum ability to match clients to the most appropriate service level.

1. Role of the Single Source Authority - State Department of Alcohol and Drug Programs

The State Department of Alcohol and Drug Programs would be responsible for the administration of an alcohol and other drug managed care service system. This would include responsibility for all federal SAPTBG funds and the delegated authority from the Department of Health Services (DHS) for the administration of Drug/Medi-Cal funding. This function includes appropriate financial review and auditing functions.

Also, under the construct of a managed system of care, the role of the DADP would likely include the additional following responsibilities and authorities:

1. Development of a process and specific criteria to establish broker or brokers of alcohol and other drug services at the county, State, regional or other appropriate population or geographic specific level.

2. Development of a new funding mechanism or modification of the existing contract mechanisms to accommodate capitated prospective payments to brokers of service networks. This would include the development of statutes, regulations, and/or policies relative to financial risk sharing between the State as payer, the counties, regional collaboratives or managed care organizations as broker, and providers.

3. Clearly define the minimum service benefit package as well as priority populations and potential treatment duration limitations.

4. Articulate the relationship between Drug/Medi-Cal benefits and SAPTBG services.

5. Define the relationship, both financial and programmatic, between alcohol and other drug services and primary medical services, public health services, mental health services, social services, education and criminal justice, and other ancillary services.

6. Apply for the necessary federal HCFA or other waivers and develop State statutory/regulatory authority to implement services in a managed care framework.

7. Develop a sound evaluation plan (short and long-term) for measuring the effectiveness and outcomes of providing alcohol and other drug services in a managed care environment.

8. Retain the authority to determine the scope, duration and unit of service rates for all publicly funded alcohol and other drug services.

9. Serve as the single statewide Payer or Insurer, establishing the standards of services and the program benefit structure under appropriate statutory and/or regulatory authority.

10. Be responsible for formulating capitation rates on a statewide basis and contracting with brokers should a fully capitated managed system of care be recommended and implemented.

11. Be responsible for licensing of all alcohol and other drug treatment and recovery programs and facilities, and Drug/Medi-Cal provider certification.

12. Be responsible for the development and support of a standardized statewide data collection and management information system (MIS).

13. Be responsible for inter-system evaluation of the managed care service system and other statewide research studies for determining cross-system outcomes and performance.

2. Role of the BROKER of Alcohol and Other Drug Services

Generally, the role of the Broker is to function as the fiscal intermediary, local administrative manager, and to establish and ensure access to alcohol and other drug services. The Broker would determine how to offer and provide access to local population-based alcohol and other drug services and funding priorities, within available funding. If the federal government continues with categorical funding and set-aside requirements, system brokers would need to continue to meet these requirements. Additionally, brokers would be required to comply with all appropriate laws, regulations, licensing practices and policies mandated by public and private alcohol and other drug funding sources, e.g., Medicare, Block Grants, State General Funds, insurance, other public benefits, and other contractual requirements, as appropriate.

Creation of a broker function in the alcohol and other drug managed care plan could be accomplished in phases. Initially, a "managed" fee-for-service system could be implemented before moving to a system with full risk and capitation. The rationale for implementing a broker in a managed fee-for-service model includes the following:

1. A broker model would initiate cost containment strategies by utilizing a gatekeeper function to assign alcohol and other drug clients to the most appropriate level of services and by monitoring contract providers for appropriate admission, utilization and discharge criteria; and,
2. A broker model would begin to establish a more comprehensive array of services while beginning to control growth of alcohol and other drug service costs.

The Broker would have the ability to organize its alcohol and other drug delivery system in accordance with local/regional requirements. This strategy allows for the design, implementation and stabilization of alcohol and other drug service delivery, while establishing other system design changes in the areas of funding and fiscal management, quality assurance and linkages.

The Broker functions could be administered by existing county alcohol and drug program offices. Benefits from the counties serving in this role include their familiarity and experience in contracting with the private community-based alcohol and other drug provider networks, and in managing the SAPTBG-funded services. Additionally, county alcohol and other drug programs are, in theory, more closely linked to other county public service systems, such as primary health, social services, criminal justice, and mental health.

However, based on geographic, financial and other considerations, the broker functions may be assigned to a regional alliance or collaborative, a Managed Care Organization, or another third party organization. Allowing local flexibility and control in order to serve constituents in the best manner possible is one of the key elements of designing an alcohol and other drug managed system of care.

At a minimum, the responsibilities of the Broker would include the following:

1. Assumes risk for services to covered beneficiaries under specified fiscal agreements/contracts (e.g., consolidated, capitated, fee-for-service) and the fiscal management and documentation necessary to meet the conditions of the agreements/contracts. Includes market analysis and provision of access to alcohol and other drug service provider network(s).
2. Develops a local/regional comprehensive array of alcohol and other drug services that serve eligible beneficiaries within defined geographic areas within funding constraints.
3. Conducts continuous quality improvement and ensures implementation, ongoing coordination and evaluation of Quality Management Plans.
4. Ensures that comprehensive linkages and coordinated access to appropriate ancillary service systems, such as mental health, criminal justice, public and primary health, and social services, are developed and maintained.

Criteria for assignment of a Broker may include the following:

1. Broker shall be knowledgeable and experienced in the specialty of alcohol and other drug treatment and recovery programs, especially in the community- based, private nonprofit provider network established in California. The Broker should be able to demonstrate specific and successful experience in utilizing private community-based providers in contractual relationships for the purposes of providing a comprehensive alcohol and other drug service network.
2. Broker shall have knowledge and experience in the area of financial management of alcohol and other drug treatment and recovery programs. The Broker should be able to demonstrate experience in maximizing financial resources. This experience should include financial management of third-party billing systems such as Medi-Cal, federal block grant funding requirements, state funding, county funding, and foundation grant funding.
3. Broker shall have specific knowledge and experience in cost controls and cost containment strategies, while maintaining the quality of alcohol and other drug services, consistent with managed care principles and practices.
4. Broker shall have successful experience in participating in a standardized statewide data collection system, consistent with the identified needs of the State and federal governments, in order to capture appropriate client assessment, utilization and cost data in a timely manner.
5. Broker shall have demonstrated successful experience in linking alcohol and other drug services to other systems of care, such as primary health, mental health, social services, and criminal justice systems.

3. Role of Alcohol and Other Drug Service Providers

A guiding principle of the alcohol and other drug managed system of care is to optimize the existing treatment and recovery service network that has been developed in California over the past three decades. California's network of service providers is directly responsible for client management, successful client outcomes, ensuring quality programs, and hence, the overall success rates of the entire alcohol and other drug field.

Under managed care, providers would continue to provide quality, multi-faceted alcohol and other drug prevention, treatment and recovery services to the clients and participants. Providers entering a managed system of care would experience some changes primarily in the areas of administrative, fiscal and operational systems. Entering into a more fully defined system of services at a statewide level would result in the design of shared policies and protocols. This will allow for enhancement of the AOD field's ability to articulate service benefits and support providers in collecting information about service goals, services delivered, performance outcome measurement, and continuous quality improvement. Thus, changes in provider administrative, fiscal and operational program policies and procedures may be required to fully implement any elements of system design.

4. Fiscal Sources

Under a fee-for-service system, limited administrative and programmatic tools are available to assist in the management of alcohol and other drug service delivery systems. If the alcohol and other drug field is to ensure the delivery of effective, cost-efficient prevention, treatment and recovery services, stabilized funding plans that support administrative and programmatic measures to manage access, service placement, quality assurance and costs need to be developed.

Under managed care, the utilization of a variety of funding approaches incorporating a defined system broker/gatekeeping function, could ensure that a full array of quality, comprehensive services are consistently provided while balancing cost effective/efficient management strategies.

a. Payment Methods

An initial step in the transition to managed care is the transfer or consolidation of all publicly designated alcohol and other drug funds into the system. The next step is capitation, defined as a method of paying a provider a fixed price per person served for a defined range of services within a specific time period.

Under a fully capitated alcohol and other drug managed care service system, the Department of Alcohol and Drug Programs, as the funder/payer of statewide public alcohol and other drug services, would provide an annually calculated amount of funds to the local/regional alcohol and other drug brokers who then contract with capable providers to deliver comprehensive, quality, cost effective alcohol and other drug services. Brokers and providers generally share the financial risk and potential benefits of managing the service system within available funding. The funding levels are usually calculated on a per person per month/year basis, multiplied by the number of clients in the targeted population. Issues of risk limitation and what types of strategies are required to reduce risks for both brokers and providers are negotiated.

While the MCPAC is recommending that alcohol and other drug services be defined as a unique and distinct service specialty within the health and human services field, discussions of whether to capitate alcohol and other drug services and related funding into an existing service system have not yet occurred.

b. Performing Actuarial Studies

As we evaluate the various financial alternatives including capitation, it is imperative that the data used to project target populations, needed services and related costs be as accurate as possible. Recent discussions between the Center for Substance Abuse Treatment and the Department of Alcohol and Drug Programs have resulted in plans to perform actuarial studies that provide an analysis of the current system's services and costs, as well as analyses of projected costs for variations of the current system within a managed care construct.

The following is a description of selected elements of the proposed actuarial study workplan:

1. Building the financial model of the current system:
   - Obtain a detailed description of the current services.
   - Identify the population receiving services.
   - Identify the types of funding sources and amounts.
   - Map the funding source to regions, providers and services.
   - Use the Drug/Medi-Cal claim system to calculate expenses, service counts, service costs.
   - Reconcile the funding amounts with the claims system expenses.

2. Calculating per capita costs for the current system:
   - Determine current utilization rates per 1,000 covered population.
   - Determine the average service unit costs from the claim system.
   - Trend utilization and costs forward to multiple future years.

- Calculate per capita costs of substance abuse benefits.

3. Analyzing alcohol and other drug service benefits to other populations (uninsured, indigent, private):
   - Estimate the number of lives in each population.
   - Obtain demographic characteristic information on each population categorized by age, gender, ethnicity groupings as well as proportion with substance abuse coverage.
   - Determine the current services available to and coverage levels for each population.
   - Compare the expected prevalence rates to the treatment prevalence rates with each population.
   - Analyze current utilization rates (if any) and unit prices within each population.
   - Calculate the aggregate and per capita costs under the current system for each population.
   - Develop assumptions (such as utilization rates, unit prices, and treatment prevalence rates) for pricing the expanded system.
   - Compare the utilization and unit price assumptions with the life counts to estimate the aggregate and per capita costs of the expanded system.
   - Compare the aggregate costs of the expanded system to the costs under the current system of each population.

RECOMMENDATIONS Re: Administration and Financing in an AOD Managed System of Care

1. The AOD field should continue to engage in a thorough assessment of the various types of financing structures that could best support an alcohol and other drug managed system of care. The assessment should include considerations in the following areas: consolidation of all direct AOD public funding sources; capitated models; managed fee-for-service (FFS) models; shared or integrated funding models; and other appropriate rate reimbursement methods.

2. Design an alcohol and other drug managed system of care which is capable of accessing and utilizing multiple sources of public funds to provide AOD services to eligible clients/participants, and, considers possible inclusion of private sector financial resources that have the potential to further support the needs of individuals and communities in California.

3. Develop specific statewide protocols and standards for AOD Managed Care System Brokers who will be responsible for managing the delivery of publicly funded alcohol and other drug services at the local, regional, or other geographical/population defined level.

4. Review multiple options and determine what entity or entities should be considered eligible to contract as the AOD Managed System of Care Brokers in California counties, regions and communities, including the following: (a) counties as Broker with first right of refusal based on historical commitment, experience, ability and mandates to serve the public sector population; (b) public or private integrated service system, and/or (c) other private/public local, state or regional HMOs, consortia, or managed care organizations with demonstrated experience in managing AOD and public sector population needs.

5. Further develop and evaluate multiple system design options for implementing an AOD managed system of care that best meet the needs of the populations to be served, e.g., as part of the primary health care benefit package, as part of the mental health benefit package, or as a separate and distinct AOD benefit package. Prioritize approaches that support local/regional goals and best serve the needs of participants/clients in each community.

6. Defer making definitive recommendations at this time that would require a commitment to placing the **management** of the public sector AOD service benefit under a specific service system.

7. Support the implementation of an actuarial study of the alcohol and other drug service system in California to determine population trends and assist in determining the costs and resources needed now and in the future to provide AOD services to eligible public sector clients and participants.

8. Conduct research of existing federal and State legislative, licensing and regulatory mandates that define current public sector AOD administrative and financial requirements for delivering AOD prevention, intervention, treatment and recovery services in California.

9. Analyze outcomes of this research and determine the types of federal, State and county regulatory or legislative changes or waivers which would be required to implement the components of an AOD managed system of care, such as the following: defining eligible populations; defining access criteria; establishing system brokers and gatekeepers; defining roles and responsibilities of service providers; and, delineating quality assurance methods.

10. Analyze AOD service utilization and develop methods to prioritize current AOD funding resources. Analyze and consider possible benefits to consolidating the fee-for-service heroin detoxification benefit within the comprehensive AOD service benefit package.

C. Defining the Array of Services

While California has a rich array of diverse alcohol and other drug services available throughout the state, the services are not formally defined under an array of care, nor are there consistent standards, protocols or outcome measures applied across the system. Treatment and recovery approaches vary by both the services that are provided and the settings in which they are delivered. Services are provided in communities by both traditional alcohol and drug programs as well as by other service systems, such as heroin detoxification services in DHS, dual diagnosis in mental health, and primary prevention in education.

It is well-known within the alcohol and other drug field that the longer the length of treatment, the better the client/participant outcomes. Philosophically, as well as fiscally, it is better to place a client/participant in a higher level of care and have them succeed than to put the client/participant in lower levels of care and have them fail several times. Hence, the alcohol and other drug array of services should not be arranged into a traditional continuum: access to the array should be based on alcohol and other drug service necessity and not on movement through a rigidly defined continuum of care.

A comprehensive array of specialized alcohol and other drug services and settings is necessary to address the multiple needs of individuals who seek help for their alcohol and other drug problems. Under an alcohol and other drug managed system of care, a clearly defined scope of specialty services incorporating minimum service access, delivery standards and cost efficiency measures will have to be established.

The following service descriptions provide a full array of services that are recommended as reimbursable services to be included in the alcohol and other drug managed care services system.

1. Prevention

a. Primary and Secondary Prevention -- These are services which are designed to either prevent persons from experimenting with alcohol and drug use or to stop or reduce the continued exposure to persons who are in the very early stages of alcohol and other drug abuse, or who are at high risk of exposure.

   Services in this category include a wide variety of options, which may include but not be limited to:

   - student assistance programs;
   - school, employment and community prevention;
   - public media campaigns;
   - alternative activity and/or recreation programs;
   - environmental prevention program strategies, which may include distribution and exposure strategies through regulation and statute;

- community organization and activity strategies; and,
- client education about the risks associated with alcohol and drug use, which may include clinical screening and health promotion.

b. Tertiary Prevention or Intervention -- This level of prevention is most closely linked with entry into treatment and recovery programs. It includes preliminary and brief counseling strategies with the prospective client and/or their significant others as a means of facilitating a treatment and recovery admission. This strategy is also categorized as "pre-contemplative" consultation and could include brief assessment and referral activities.

2. Assessment, Evaluation and Referral

A structured review and evaluation of the individual's alcohol and other drug problem(s), including, when appropriate, consultations with family, employers, and significant others to assist in the assessment, diagnosis and proper referral of the individual.

3. Detoxification / Methadone Maintenance

Medical and/or psychological management of an individual while he/she withdraws from alcohol and/or drugs.

Service modalities would include:

- Residential Detox in either licensed Social Model Recovery Homes or in licensed medical model settings
- Nonresidential Detox such as home-based detox
- Chemically-assisted Detox (includes Naltrexone and other chemically assisted services)
- Detox from Methadone

4. Non-Residential Services

An organized non-residential service or an office practice with designated alcohol or other drug treatment and recovery personnel or addiction-credentialed clinicians that provide evaluation, treatment and recovery services to addicted clients and collaterals. Services are provided on a regularly scheduled basis.

Service modalities would include:

- Outpatient Drug Free counseling
- Day Care habilitative counseling
- Crisis Intervention
- Social Model Non-Residential Recovery

5. Residential Services

Residential programs provide services with designated program staff. Services may include assessment and evaluation, health assessment, alcohol and other

drug treatment and recovery services, education services, daily living skills training, interpersonal skills, independent living skills, counseling, recovery orientation, pre-vocational services, and assistance with housing.

Service modalities would include:

- Perinatal residential
- Therapeutic community services
- Social model residential recovery
- Transitional residential services such as half-way houses

6. Case Coordination /Case Management

Case Coordination /Case Management would be provided through all service areas and includes needs assessment, setting of objectives related to needs, individual service planning, service scheduling and periodic evaluations of service effectiveness. Case coordination services ensure that the changing needs of alcohol and other drug clients are addressed on an ongoing basis and that appropriate choices are provided among the widest array of options for meeting those needs.

Case Coordination /Case Management includes the following: assessment (not diagnosis of service or medical necessity, as the client has already been admitted into the alcohol and other drug treatment/recovery service system); service and treatment plan development, linkage and consultation; assistance in accessing services; crisis assistance planning; and, periodic service/treatment plan review.

7. Ancillary Support Services

Services may include advocacy for and linkages to child care, outreach, and interim support services.

RECOMMENDATIONS re: Defining the Array of Services to be Delivered in an Alcohol and Other Drug Managed System of Care

1. The AOD managed system of care in California should include a comprehensive array of alcohol and other drug prevention, intervention, treatment and recovery services for all age and population groups, which, at a minimum, includes the following:
   - Prevention/early intervention strategies and services;
   - AOD service/medical necessity assessment/evaluation and referral services;
   - Residential and non-residential detoxification services;
   - Residential and non-residential treatment and recovery services;
   - Medication-managed and maintenance services;
   - Chemically-assisted and drug free detox;
   - Case coordination/case management services; and,

- Formal linkages to ancillary support service systems that support successful prevention, intervention, treatment and recovery outcomes.

2. The AOD field should develop and agree to clear descriptions of prevention, intervention, treatment and recovery modalities that can be understood by all those accessing the AOD system of care. These descriptions should include, at a minimum, recommended scope, settings and duration for each of the service modalities.

3. The utilization of clear and consistent AOD service descriptions would offer assistance in placing clients/participants in the level of care that best meets their needs; provide guidance for developing and managing individual and group service plans; enhance continuous quality improvement efforts; and, promote effective linkages with ancillary service systems.

4. The alcohol and other drug field should develop and agree to the following: clearly described AOD prevention and intervention services; target and/or priority populations to be served; provider qualifications; measurable outcomes; and, efficient cost methodology to ensure the delivery of prevention and intervention services within all areas of an AOD managed system of care.

5. Access to and utilization of the array of public sector AOD services by eligible clients/participants should be determined by the outcomes of their AOD service necessity assessment and identification of their specialized needs.

6. The AOD managed system of care should incorporate policies and guidelines to ensure that access to AOD services will not be determined by any policies, now or in the future, that require movement through a too rigidly defined continuum of care.

7. Develop specific protocols to ensure that the full array of services in an AOD managed system of care competently respond to the diverse cultural, ethnic, linguistic, lifestyle and disability needs of covered populations. These protocols should be required by AOD managed care broker(s) and incorporated into contract agreements negotiated by State and public entities responsible for payment of services for public beneficiaries.

8. Develop definitive strategies to provide access to the full array of AOD prevention, intervention, treatment and recovery services and meet the unique service needs of public sector populations and providers in rural and frontier communities throughout California.

D. Access to Alcohol and Other Drug Services in a Managed System of Care

Historically in California, there has been a decentralized approach to how populations gain access to and receive alcohol and other drug services. In most counties, alcohol and other drug service providers independently determine the intake criteria, length of stay and time of exit of the clients/participants in their programs. Publicly funded services are generally contracted through county alcohol and drug program administrators who maintain responsibility for monitoring the programmatic, administrative and fiscal performance of individual alcohol and other drug service providers.

Within a managed system of care, the development of a more uniform and consistent approach to determining client/participant access to the public alcohol and other drug benefit will need to be developed. Essential elements include:

- defining the characteristics of beneficiaries eligible to receive public funds to pay for alcohol and drug services;
- establishing criteria that define alcohol and other drug service/medical necessity and provide guidance to service level placement;
- establishing a system entry, or gatekeeping function, that authorizes access to the public alcohol and other drug benefit by directly implementing or managing client/participant assessment protocols.

1. Defining Access to the Alcohol and Other Drug Service System Utilizing Gatekeeping Functions

An essential feature of managed care is to ensure that the specialized service received by the clients/participants be provided in a manner that best serves their needs and achieves the best outcomes. An appropriately designed and implemented system access or gatekeeping function has the potential to successfully facilitate this goal.

As previously described, a Managed Care Plan Broker contracts with funding sources (or payers) to manage and ensure the provision of selected alcohol and other drug benefits/services to defined, eligible populations. The Broker then negotiates service contracts with specialty alcohol and other drug providers to deliver services to these defined and eligible groups as needed under a prospective payment agreement. To assure appropriate and expedient access to the alcohol and other drug service system, the Broker will need to develop, implement and manage an effective client/participant intake process. An alcohol and other drug gatekeeping approach could be utilized within any type of integrated or specialty service assessment systems at the local or regional level.

At a minimum, the gatekeeping function would incorporate the following responsibilities:

- Conducts preliminary intake assessment to screen clients/participants for:

1. Eligibility to receive public funds and any co-payment responsibility;
2. Assessment of alcohol and other drug service/medical necessity and other specialty needs;
3. Determining appropriate service placement and/or referrals within the alcohol and other drug or ancillary service systems.

- Authorizes access to publicly funded benefits;
- Ensures adherence to State and federal system regulations by provider network, e.g., Drug/Medi-Cal, program licensing/certification standards, SAPTBG;
- Collects, analyzes, and distributes data as part of a MIS system and outcome evaluation to managed care system brokers, State DADP/DHS, other funders and entities as mandated and required;
- Authorizes payment for service benefit provision by provider network;
- Provides liaison between Broker, State, other funders, field and professional entities, and all providers within the service system network; and,
- Assures compliance with established, standardized assessment and intake protocols for all providers within the service system network.

2. Defining Client/Participant Access to Alcohol and Other Drug Services - Assessment of Service Necessity and Determining Level of Placement Criteria

Significant adverse changes in a person's health, social, relationship, family, work, economic, legal, educational, environmental or other conditions suggest that a thorough assessment be conducted to determine the possible presence of an alcohol or other drug problem. The alcohol and other drug field currently utilizes many types of assessment criteria and related instruments/tools to determine the need for individuals, families, groups and communities to receive alcohol and other drug prevention, intervention, treatment and recovery services. In the arena of treatment and recovery, there already are several assessment tools to assist in determining client alcohol and other drug service/medical necessity and service placement. These offer the possibility of shared utilization by diverse providers.

In an alcohol and other drug managed system of care, service providers and brokers will need to identify common elements that each will utilize as minimum assessment criteria for determining alcohol and other drug service necessity and supporting recommendations for service level placement. The selected elements should incorporate a systems approach to quality and effective client assessment and placement, have utility on a statewide basis for MIS purposes and outcome tracking, and allow for flexible implementation methodology at the local/regional level.

Development of defined elements and/or tools for use in performing both preliminary and in-depth client/participant alcohol and other drug service necessity and placement within a managed system of care offers the alcohol and other drug field numerous opportunities to engage in ongoing evaluation and continuous quality improvement of the service system. Data collected would have reliability and validity for possible future use in comparative measurement of client status at the start of treatment/recovery, and at subsequent evaluation points, as a means of defining improvement. Standardized data collection elements could be used to:

- evaluate the initial treatment/recovery needs of clients/participants;
- collect demographic and clinical information of the client/participant population in a standard manner to assess and describe change over time;
- assess the efficacy of the treatment/recovery offered; and,
- identify cause and effect in lifestyle changes.

The selected assessment elements, at a minimum, should include methods to identify client/participant needs in the following areas:

- current level of alcohol and/or other drug use;
- medical conditions / at-risk factors;
- mental / emotional health status;
- legal status and criminal history;
- educational history;
- employment history/employability;
- social functioning;
- family-support system functioning;
- motivation / treatment readiness;
- alcohol and other drug treatment/recovery history;
- environment in which client/participant resides; and,
- special needs, including disability requirements and language/cultural needs.

3. Consideration for the Alcohol and Other Drug Field to Develop and Utilize Level of Function (LOF) Assessment Criteria to Assist in Determining Alcohol and Other Drug Service Necessity, Level of Service Placement, Treatment and Recovery Plan Guidance and Outcome Measurement

The Level of Functioning (LOF) scale has been adapted from the Global Assessment of Functioning scale of the DSM-IV. The LOF is designed to be utilized by each broker/gatekeeper of the Alcohol and Drug Managed Care program as a preliminary means of assessment and placement guidance. It is further proposed that the LOF score will be identified at intake, at selected time intervals during AOD treatment/recovery services, upon completion of services or discharge, and during follow-up as one means of outcome evaluation.

The LOF is not intended to be a comprehensive assessment tool for clinical/ programmatic purposes or for the development of a comprehensive treatment and recovery plan. Therefore, programs must continue to utilize an assessment instrument in addition to the LOF. Further, since the LOF is not designed to take the place of clinical judgment, especially when evaluating acuity level and social/environmental conditions of a client/participant, referrals to a level of care continue to be subject to staff concurrence and recommendations.

Guiding Principles:

- Assignment of LOF is based upon a client's ability to assume personal responsibility for dealing with alcohol and other drug related issues or problems. A higher level of responsibility should require a lower level of care.
- All functional difficulties are to be a direct result of alcohol and other drug involvement.
- Service placement must accommodate the available service delivery system and available capacity.
- Service placement analysis should include client involvement and preference in the selection of the appropriate service level.

Additionally, to be considered by MCPAC are several "patient placement criteria" instruments that have been developed by private companies, including: Green Spring Utilization Review Criteria; Mental Health Review Criteria; Level of Care Guidelines; and Guidelines for Level of Care Decisions. Several other states have developed new or adapted elements from existing models to utilize within their alcohol and other drug service system. In general, these instruments assess the client/participant's level of functioning and family or social supports.

RECOMMENDATIONS re: Client/Participant Access to Alcohol and Other Drug Services in a Managed System of Care

1. Establish formal methods and protocols for AOD managed system of care entry/gatekeeping functions that: (a) authorize access to AOD services; (b) provide guidance to service level placement; and, (c) collect data for a required minimum data set and outcome assessment/evaluation.

2. Implementation of methods to provide the system access/gatekeeping functions within an AOD managed system of care does not necessitate performance of these functions by a single provider or at one geographic location.

3. The access/gatekeeping system designs and implementation methodology should be developed to respond effectively to the needs of clients/participants and providers at the local/regional level.

4. Develop a two-tier client/participant intake assessment process for AOD treatment and recovery services:
   - Preliminary Intake Assessment at system entry/gatekeeper level; and,
   - In-Depth Client/Participant service needs evaluation for treatment and recovery planning at the AOD service provider level.

5. Develop and implement a standardized minimum set of data elements for collection at each tier of the client/participant assessment process (system entry/gatekeeper and AOD service provider levels). The data elements could also be used for assessing other eligibility criteria and for payment authorization.

6. At a minimum, standard assessment elements should be developed and confirmed by the AOD field for use with all public sector contract providers. Modifications to an existing or development of a new standardized AOD services assessment/placement instrument is strongly recommended for further consideration.

7. Further evaluate and consider acceptance of the proposed Level of Function (LOF) Guidelines developed by MCPAC work teams as standard elements to be utilized by all publicly funded alcohol and other drug service providers for assistance in:
   - assessing alcohol and other drug service necessity;
   - determining levels of service placement;
   - development of the initial and ongoing client/participant treatment and recovery plan;
   - quality assurance/improvement;
   - management information systems; and,
   - evaluation of short and long-term prevention, intervention, treatment and recovery outcomes.

8. The development of assessment protocols which ensure access to alcohol and other drug services and which competently respond to the diverse cultural, ethnic, linguistic, lifestyle and disability needs of covered populations should be required by the AOD managed system of care brokers and incorporated into contract agreements negotiated by State and public entities responsible for payment of services for public beneficiaries.

9. Develop definitive strategies to meet the unique access service needs of populations and providers in rural and frontier communities throughout California.

10. If the AOD managed care system operates exclusively as a capitated system or includes capitated contracts under its administrative and financial structure, then the system access/gatekeeping function should be assigned to the entities at risk.

E. Preparing for Quality Assurance in a Managed Care Environment

Currently in California, formal Utilization Review criteria and methods for implementation are required for all providers who offer Drug/Medi-Cal services as well as for providers operating in medical and clinical settings. Although many social and community model programs also engage in a regular evaluation of their services, they are not currently required to engage in traditional Utilization Review practices, and there are no current mandates outlining specific quality assurance standards.

Under managed care, Quality Assurance (QA) protocols, ensuring that alcohol and other drug services are effective, efficient and performed consistently within any required laws and regulations, would need to be developed. Alcohol and other drug system QA protocols need to be responsive to the special needs of various service modalities and funding sources.

1. Components of a Quality Assurance System

The following components have traditionally been included under a Quality Assurance System. Under managed care, a QA system would be developed that is responsive to the unique needs and requirements of alcohol and other drug clients/participants and providers.

a. **Prior Authorization**: Some health care systems have developed a process requiring prior treatment authorization before admission or payment of services. The alcohol and other drug system has historically not used this process. However, some consideration should be made to use such a system for admission to potential high cost or long-term services such as in-patient hospital detoxification, methadone maintenance, or long-term residential treatment/recovery.

b. **Quality Improvement**: Traditionally, a Utilization Review Committee (URC) is formed, which reviews cases retrospectively to ensure that medical necessity is present, treatment/recovery plans are appropriate, and documentation and authorizing signatures are completed. The URC can also authorize additional continued treatment/recovery in incremental quantities or recommend termination of treatment. UR is a federal Medicaid requirement.

c. **Peer Review**: Many health care systems have traditionally utilized Peer Review for physician level treatment review and evaluation. In the alcohol and other drug field, the federal SAPTBG funding requirements include peer review as a necessary QA function, but do not specify level of staff requirements.

d. **Client Satisfaction Surveys/Grievance Process**: The State alcohol and other drug system is required to maintain a client grievance process which

flows from the provider level, to the county level, and then to the State level. This is not currently well formulated and should be reviewed to ensure its effectiveness. Other health systems have utilized formal Patient Rights Advocates to strengthen this function.

e. **Program Standards and Protocols**: It is critical that quality assurance functions be compared against program standards and protocols in order to ensure that services are being provided in a manner and a level that is effective, safe, and in accordance with therapeutic principles. Under managed care, clearly defined program standards, staffing patterns, and scope of practice issues for both social model and clinical model programs will need to established. A primary goal in this area of quality assurance is to determine whether the services being provided are responsive to the client's needs.

f. **Service Provider and Counselor Qualifications**: This is a process that has been included in the quality assurance methodology of other service systems. The California alcohol and other drug field does not currently utilize a standardized substance abuse counselor qualification or certification process. Under managed care, and to be eligible for HCFA waivers, the alcohol and other drug service system must clearly demonstrate that qualified staff are working in alcohol and other drug treatment and recovery programs. The alcohol and other drug managed system of care will need to develop specific recommendations to define minimum competency standards, including scope of practice and certification requirements for alcohol and other drug service specialists.

g. **Program Credentialing and Facility Licensing**: The State Department of Alcohol and Drug Programs currently licenses only residential programs and methadone maintenance facilities. Drug/Medi-Cal programs must be certified. Under managed care, we would need to fully consider the benefits and contra-indications for credentialing and/or licensing ALL alcohol and other drug treatment and recovery facilities in California.

h. **Provider Grievance Process**: Should flow from a county/local /regional level (the funder) to the State level.

The combined array of review processes and administrative requirements are designed to ensure that clients are afforded the best possible treatment and recovery services within safe and sanitary environments. The alcohol and other drug system must also decide how these processes are to be implemented, and define the roles and authorities of providers, the counties, and the State.

RECOMMENDATIONS re: Quality Assurance in an AOD Managed System of Care

1. The Single State Agency, the Department of Alcohol and Drug Programs (DADP), responsible for overseeing the public AOD system of managed care at a statewide level in collaboration with the AOD field, should develop quality assurance elements for inclusion in a Quality Management Plan (QMP) for managing and providing public sector AOD services that are appropriate to each service modality and responsive to requirements of diverse funding sources.

2. The QMP would be used by all public sector AOD managed system of care brokers to objectively and systematically monitor and evaluate the quality and appropriateness of services to clients, pursue opportunities to improve access and quality of services and resolve identified problems.

3. The Single State Agency (DADP) and the AOD field should periodically review the design, implementation and effectiveness of the QMP.

4. Minimum standards for competency should be developed for alcohol and other drug treatment and recovery staff.

5. Develop specific protocols to ensure that the QMP in an AOD managed system of care competently respond to the diverse cultural, ethnic, linguistic, lifestyle, and disability needs of covered populations. These protocols should be required by AOD managed care brokers and incorporated into contract agreements negotiated by State and public entities responsible for payment of services for public beneficiaries.

6. Develop definitive strategies to ensure that the QMP meets the unique service needs of public sector populations and providers in rural and frontier communities throughout California.

F. Performance Outcome Measures

A primary tenet of managed care is the evaluation of the effectiveness of the services that the client/participant received. This evaluation is generally termed "outcomes monitoring" which can be defined as the assessment of client/participant status in key life areas (for example, family/social relationships, employment or legal status) related to alcohol and other drug problems during and following treatment/recovery. In managed care, a key determinant is that changes in programs, budgets, and/or staffing for continuous improvement should result from the analysis of the outcomes monitoring system.

An <u>outcomes monitoring system</u> (OMS) differs from program evaluation, quality assurance systems, and experimental research.

Program Evaluation: Goal is to improve service delivery and focuses on a specific program.

Quality Assurance: A program is generally judged against uniform standards and practice parameters, and accreditation or Licensing is granted for attainment of those standards.

Experimental Research: Purpose is to expand the knowledge base, and is focused on theory development and hypothesis testing.

OMS: The goal is to improve client/participant outcomes.

An OMS is a broad-based effort that aggregates data from many programs and often uses less rigorously designed research protocols. In the case of publicly-supported programs, an OMS primary purpose is to establish accountability for the expenditure of public funds. It is important, however, that the system not become too cumbersome for participating providers to supply accurate data. Similarly, it is important to acknowledge that all information that is collected has a cost, and the cost of the data must be balanced with its overall utility to the system.

Assessing client/participant outcomes is critical in any managed system of care to ensure that the well-being of clients/participants is foremost, and that fiscal outcomes are evaluated in terms of the benefits derived by clients/participants. Assessing client/participant outcomes can also ensure that appropriate benefits levels are maintained and that treatment/recovery thresholds (the minimum treatment/recovery doses needed to create the desire effect) are met.

Data Collection Points

A client-level outcomes monitoring system is built on a standardized data system, which incorporates data collection at standardized strategic points as a client/ participant moves through the treatment/recovery system. How and when to collect data on clients receiving prevention services requires further discussion and analysis.

1. **Initial assessment** *(to determine the appropriate level of services)*
   An OMS starts with the initial assessment of placement in the appropriate level of care. Outcome data must be examined to determine whether the assessment, placement and treatment/recovery decisions were on target.

2. **A comprehensive assessment** *(to develop a treatment/recovery plan and/or goals)*
   In addition to determining the appropriate level of care, an assessment to determine which treatment/recovery and/or ancillary services are required is needed. These data items can be classified (although there is much overlap) as "predictor" or "baseline/outcome" elements.

   Predictors include:

demographics	medical history
education	psychiatric history
vocational history	legal problems

social history
alcohol and other drug use
previous treatment/recovery
motivation
treatment/recovery readiness

Baseline/outcome elements include:

alcohol and other drug use frequency
alcohol and other drug use amount
mode of administration
HIV risk behaviors
alcohol and other drug dependence symptoms
family/social relationships
other "risk" behaviors (suicide)
physical health
psychological health
employment
financial stability
legal problems
criminal activity

Collecting similar data elements at the initiation of treatment/recovery and repeating the measure at follow-up allows for the comparison of client/participant change and the assessment of treatment/recovery effectiveness.

3. **As the client/participant receives services** *(to determine which treatment/ recovery components and modalities were utilized by the client/participant)* Treatment/recovery variables have an important role in understanding outcomes. One of the most frequently discussed issues is related to the cost of care, which includes the setting and staffing. If different programs or modalities achieve similar outcomes at differing costs of care, then costs alone may be the basis for choosing one program over another. Understanding what differences exist in the quality or intensity of the programming is crucial for understanding different outcomes based on different treatment/recovery populations. If only baseline and outcomes data are collected, what differs between programs will be unknown, and making determinations of appropriate placement based on the client/participant's level of functioning will not be possible.

4. **At discharge from the treatment/recovery services**
The client/participant's discharge status and a repeat of the baseline measures at the time of discharge from the program are vital to collect. Successful treatment/recovery completion can serve as an intermediary outcome measure. Many states (e.g., Kansas, Minnesota, and Ohio) collect the same measures at discharge and repeat them at another point in time.

5. **Post-discharge** (*to document the client/participant s status either through contact with the client/participant or through the use of collateral records)* Generally, the more expensive part of an OMS is the post-treatment follow-up data collection. When clients/participants are no longer involved with the provider, locating and collecting information from them can be very time consuming. In addition, using program staff to conduct the follow-up interview can produce biased results. However, without the longer-term follow-up to

ascertain what the longer-term effects of treatment/recovery are, we cannot make the cost-effectiveness decisions on levels of care.

RECOMMENDATIONS re: Performance Outcomes Measurement in an AOD Managed System of Care

1. Develop and adopt client/participant placement criteria elements and consider utilization of a standardized instrument.

2. Develop and adopt client assessment guidelines.

3. Develop level of outcomes to be measured for programs that do not incorporate a client-change focus, such as environmental strategies that result in "community" behavioral changes.

4. Develop and adopt standardized, minimum data elements allowing for county, local, or regional level variations.

5. Develop and adopt a methodology to measure outcomes in prevention, intervention and treatment/recovery services.

6. Develop and adopt follow-up data collection methods.

7. Identify changes in the current management information systems that will be required to implement AOD managed system of care requirements.

8. Develop and adopt a minimum data set that incorporates cultural, ethnic, linguistic, lifestyle and disability characteristics of the populations being served.

G. Management Information Systems (MIS)

Managed care systems use data to monitor cost and outcomes by providers. These systems are sophisticated, on-line electronic systems that can support a full range of provider activities, such as scheduling appointments, billing, reporting, and tracking outcomes, client histories, assessments and demographics.

A functional, cost effective, MIS system is vital to the successful implementation of an alcohol and other drug managed system of care. Accurate, concise and timely information is needed to continually review performance, client outcomes, client satisfaction, costs, program efficiency and quality improvement. Data sets need to be developed for use by all counties and providers. Implementation issues of costs and conversion must be carefully considered and studied.

In California, there is currently no totally comprehensive statewide data system for alcohol and other drug services. However, there are several current data systems maintained and/or available throughout the state. These include CADDS, DATAR, NDATUS, licensing and certification information, contracting information, drinking-driving programs, and other State department data bases. CADDS is the current data system which incorporates client-level data and includes the minimum data set required by the federal government. At present, CADDS has very limited discharge and outcome data. However, it seems reasonable that making incremental changes to the CADDS system could incorporate discharge data in the near future. This discharge data should include information on the client's level of functioning in key areas and be operationalized so that common definitions are used across programs and locales. In addition, some very important client characteristics should also be added to the data set to incorporate a family-focus in the treatment/recovery system. These data elements include parenting status and information on other systems that family members are participating in, such as criminal justice, child protective services, and health care.

RECOMMENDATIONS re: MIS Policy and System Development in an AOD Managed System of Care

1. Recommend design and implementation of a statewide electronic data collection system inclusive of the following:
   - Selected MIS data elements;
   - Common data collection methods between providers, counties and state;
   - Cross-system data linkages/integration with social services, mental health, health, criminal justice systems. This could include design of a tracking system for clients served by multiple systems. Issues of client confidentiality must be incorporated in design of a tracking system.
   - Technical assistance training to counties, providers to develop, implement and utilize systems;
   - Technical assistance training to counties in how to best utilize collected data for all aspects of service delivery, including matching client to appropriate service, budgeting and fiscal analyses, program monitoring, outcome evaluation, and research; and,
   - DADP responsible for financial support, technology and training.

2. The MIS system developed must be responsive to the cultural, ethnic, linguistic, lifestyle and disability characteristics of populations served, and address the unique needs of the rural/frontier communities throughout California.

H. Linkages to Ancillary Services

Clients often present with multiple and complex health, social and economic problems. There are increasingly higher percentages of people with alcohol and other drug problems who also require the comprehensive care found in other service systems.

The importance of forging formal linkages with allied service systems to provide clients/participants with comprehensive services as well as to enhance treatment and recovery outcomes has been referred to frequently throughout this report. Under managed care, a clearly defined approach to ensuring and improving alcohol and other drug client/participant access to these ancillary and interconnective services is needed. Common goals and strategies must be created. The development of financial incentives will be vital to the successful implementation of these collaborative inter-system service linkages.

RECOMMENDATIONS re: Linkages to Ancillary Services in an AOD Managed System of Care

1. Clearly define what types of ancillary services should be included in the array of services in an AOD managed system of care and whether they are eligible for being funded by direct public AOD funds or should be funded from other sources.

2. Establish formal collaborative partnerships with other service specialties, including memorandums of understanding, interagency policies and procedures, that result in enhancing access to multi-disciplinary services and case coordination by AOD clients/participants. Formally coordinated inter-system policies and protocols will also result in increased service delivery effectiveness and cost efficiencies across all service systems.

3. Ancillary service linkages developed should be responsive to the cultural, ethnic, linguistic, lifestyle or disability characteristics of populations served, and address the unique needs of rural and frontier communities throughout California.

I. Cultural Competence, Linguistic and Disability Accessibility

California has one of our country's most ethnically and culturally diverse populations. Alcohol and other drug service providers throughout many California communities have strived to design and deliver services to all populations. Unfortunately, not all efforts have resulted in successful outcomes, and many populations have traditionally been unserved altogether or unable to receive timely access to needed specialty alcohol and other drug services, due to limited services within counties or to cultural, language, lifestyle and disability barriers within provider networks.

The alcohol and other drug field's move toward designing a managed care service system has caused concern among various provider and constituency advocacy groups that "managing access" to services could result in the creation of even more barriers to serving underserved communities. On the contrary, managed care may in fact provide the opportunity to better respond to all California populations by designing and integrating cultural competency goals and quality assurance and improvement standards in all areas of the alcohol and other drug service system.

"Culturally competent" services are defined as a set of congruent behaviors, attitudes, and policies that come together in a system or agency that enable the agency to work effectively in cross-cultural situations. A culturally competent alcohol and other drug managed system of care acknowledges and incorporates at all levels of care the importance of culture, the assessment of cross-cultural relations, an understanding of the dynamics that result from cultural differences, expansion of cultural knowledge, and the commitment for the development and adaptation of services to meet culturally unique needs. Access to culturally competent services should be a primary objective of the managed care alcohol and other drug services system.

RECOMMENDATIONS re: Commitment to Cultural, Ethnic, Linguistic, Lifestyle and Disability Access and Competence in an AOD Managed System of Care

1. Develop and adopt specific alcohol and other managed system of care goals and standards which ensure access to the full array of services by populations with diverse cultural, ethnic, linguistic, lifestyle and disability characteristics.

2. These goals and standards should be incorporated into contract agreements negotiated by State and public entities responsible for funding and delivering AOD services for public beneficiaries.

J. Rural and Frontier County Considerations

The problems of health care service delivery in rural areas of California include primary and specialist physician shortages, sparse service and training infrastructures, communities isolated by geographic distances and climatic conditions, population shifts due to seasonal labor, and weak economies based on single season industries that result in high unemployment rates, large numbers of welfare recipients, and small tax bases.

While large geographic areas of California may be affected, a relatively small portion of the total State population is affected, depending on how "rural" is defined. By one definition, 25 of the 58 counties would be classified as rural; however, only 4% of the state's population permanently lives in those counties. Even larger counties are not necessarily completely urban. Riverside, San

Bernardino and San Diego counties include vast areas that are "rural" by population density measures.

These issues are intensified when delivering any specialty service, such as alcohol and drug treatment/recovery services. Historically in California, the 19 smallest counties have been funded by a minimum base allocation. In general, this allocation has covered a small staff, averaging less than six counseling and prevention staff persons, and a program director usually responsible for both management and direct clinical services.

The difficulty of establishing a managed system of care in rural areas, even for primary health care, has also been well documented. Much of the debate of the health reform plan during 1993 disclosed the problems of establishing "regional alliances" in rural areas. In California, the Department of Health Services primary care planning for Medi-Cal Managed Care includes only the twelve to fourteen largest counties. Barriers to establishing plans in rural areas include the lack of competitive network providers, as well as the small population upon which to base experience ratings and spread costs.

The advantages, applicability and feasibility of implementing managed alcohol and other drug services in rural areas are unclear at best. Specific alcohol and other drug care service delivery strategies to ensure access to the full array of services by populations residing in rural and frontier counties along with financial risk imitation strategies require further evaluation development.

RECOMMENDATIONS re: Rural and Frontier County Considerations in an AOD Managed System of Care

1. Develop and incorporate specific recommendations that address the unique characteristics and needs of rural and frontier communities throughout California in all components of an AOD managed system of care design.

2. Consider exempting rural and frontier counties from requirements to enter an AOD managed system of care until models in the larger counties can be developed and tested.

V. Next Steps

A. Field/Public Review and Response to "Briefing Paper and Preliminary Recommendations Report"

As the Managed Care Committee continues its work in analyzing and recommending alcohol and other drug service system improvements through a managed care design construct, it is critical to create formal methods to exchange

and discuss findings, analyses and recommendations with the larger alcohol and other drug field. The multitude of complex issues to be addressed before an alcohol and other drug managed system of care can move toward implementation requires a comprehensive and in-depth analyses of alcohol and other drug services at all levels of the care system. Experienced alcohol and other drug and other service system experts as well as persons who receive services need to participate in this process to bring forward the best possible recommendations for serving the needs of people with alcohol and other drug problems.

RECOMMENDATIONS re: Public Review of Recommendations Report

1. Develop a formal and inclusive process, utilizing social marketing strategies, for developing and disseminating managed system of care findings, strategies and recommendations with DADP, DHS, DMH, other systems providers, constituency groups and the general public, to include at a minimum:
   - State and federal agencies
   - Director's Advisory Council - provider associations, constituent groups, general public
   - Public and private alcohol and other drug providers - statewide
   - Technical assistance contractors (DADP)
   - Affiliated professional organizations

2. Communication and dissemination methods may include the use of the following:
   - Prev Net
   - Statewide teleconferencing
   - Community forums
   - InfoWorks
   - Focus groups
   - MCPAC presentations upon request
   - Public hearings after "Preliminary Recommendations Report" Plan drafted and disseminated

3. Develop AOD field and public review processes that are responsive to the diverse cultural, ethnic, linguistic, lifestyle and disability characteristics of Californians and address the unique needs of rural and frontier communities throughout California.

B. Projected Alcohol and Other Drug Managed System of Care Implementation Process

1. Phase I (1994-96): Draft a "Preliminary Recommendations Report"

This phase focuses on the analysis of the current alcohol and other drug treatment and recovery system and will include proposed improvements to the system:

- Establish and implement a plan for public distribution, review and discussion of the Recommendations Report as well as a process for receiving feedback and comments.
- A Managed Care Policy Advisory Committee (MCPAC) will be formed with a steering committee to lead various work teams in further development of the Recommendations Report.
- MCPAC work team to develop separate recommendations report for the Department of Alcohol and Drug Programs to present to the legislature on cost containment measures for the Drug/Medi-Cal program. Due 3/1/96.
- MCPAC, DADP and CSAT to sponsor two educational conferences for providers and consumer groups to share the experience, approaches and concerns of providers from other states that have experienced managed care transitions by March 1996.

2. **Phase II: Develop a Health Care Financing Agency (HCFA) Waiver - *ON HOLD***
   Under certain conditions, a HCFA "freedom of choice" waiver will be necessary for the implementation of the gatekeeping function for the Drug/Medi-Cal treatment benefit. This phase depends on developments at the federal level concerning the future of Medicaid funding.

3. **Phase III: Development of a Financial Plan (June 1996)**
   This phase will encompass issues concerning AOD service benefits, placement of the management of the AOD system of care, target populations, rate structures and risk-sharing assumptions, and possible consolidation of the heroin detoxification benefit from the fee-for-service Medi-Cal program.

4. **Phase IV: Develop a Phased-In Implementation Plan (June 1997)**
   This phase will include completing the necessary statutory or regulatory packages, implementing a contractual process standardizing the assessment and data collection elements, and initiating the evaluation processes.
   - Implementation of a standardized contractual process between DADP and brokers.
   - Standardized assessment and data collection elements.
   - Initiation of evaluation processes.
   - Necessary statutory or regulatory packages.

VI. References

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